



Understanding the New Health Reform Law

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Long-Term Services: Provisions in the New Health Reform Law

Health reform does even more than ensure that all Americans will have access to affordable medical care. It also includes provisions to improve access to affordable long-term care. That's a critical issue that will become even more pressing as the baby-boom generation ages and the number of Americans over the age of 65 increases dramatically. In the area of long-term care, health reform includes provisions to expand access to home- and community-based care (HCBS) in Medicaid and establishes a new, voluntary long-term care insurance program.

This document outlines our best understanding of key provisions in the new law that affect long-term services. Some of this information may change as program regulations and guidelines are developed. Check Families USA's website for updates.

Key provisions include:

- **Community First Choice Option** - A new state plan option to provide home- and community-based services that includes an increase in federal matching funds for program costs
- **The State Balancing Incentives Payment Program** – A temporary program that provides qualifying states with an increase in their federal match for Medicaid Home- and Community-Based Services (HCBS) costs
- **Changes to Medicaid's 1915(i) Option for Home- and Community-Based Care** - Improvements to Medicaid's existing state plan option for providing Home- and Community-Based Services (HCBS), 1915(i)
- **The Community Living Assistance Services and Supports (CLASS) Program** - A national voluntary program to help people insure against the cost of long-term services
- **Expanded Spousal Impoverishment Protection in Medicaid** - Requires states to extend the same spousal impoverishment protections that apply to institutional care to home- and community-based care
- **Extending Money Follows the Person Demonstration Project** - Helps Medicaid-eligible individuals transition from institutions back to the community
- **Additional Funding for Aging and Disability Resource Centers** - Funding for aging and disability resource centers

Community First Choice Option

What it is

A new state plan option to provide home- and community-based services in Medicaid Section, 1915(k); available October 1, 2011. States that take up this option receive a 6 percentage point increase in federal matching payments (FMAP) for costs associated with the program.

Eligibility

States may provide services to Medicaid-eligible individuals whose income does not exceed 150 percent of poverty. States that have set a higher Medicaid income eligibility level for those who require institutional care can use that higher income level. Participants with incomes over 150 percent of poverty must also meet the state functional eligibility requirement for institutional care.

Benefits

Home and community attendant services provided in a community setting. Services for each participant must be based on an individual care plan developed through an assessment of the individual's functional need. No restrictions on state program expenditures.

- **Required Services:** States taking up this option must provide the following:
 - Assistance with activities and instrumental activities of daily living (ADLs and IADLs) and health-related tasks, including hands-on assistance, cuing, and supervision.
 - Acquisition, maintenance, and enhancement of skills to complete those tasks.
 - Back-up systems, such as beepers, that will ensure continuity of care and support.
 - Training on hiring and dismissing attendants, if desired by the individual.
- **Optional Services:** States may also provide the following:
 - Transition costs, such as the first month's rent; rent or utility deposits; and kitchen supplies, bedding, and other necessities for an individual to move from a nursing facility to the community.
 - Coverage for additional items noted in an individual's care plan that will increase independence or substitute for personal assistance.

Excluded are: home modifications, room and board, medical supplies, and assistive technology (except items that would meet the definition of back-up systems to ensure care continuity).

Providers

Services can be provided under an agency or other model. Family members, as defined by DHHS, can provide services.

Providers are to be selected and services controlled by the individual or individual's representative to the maximum extent possible. States must ensure that regardless of care model, services are provided in accordance with the Fair Labor Standards Act.

State Requirements

- **Service availability:** States must make services available statewide, with no caps or targeting by age, severity of disability, or any other criteria. Services must be provided in the most integrated setting appropriate, given an individual's needs.
- **Maintenance of Effort:** During the first year, a state must maintain or exceed its prior year Medicaid expenditure level for optional services provided to elderly individuals and people with disabilities.
- **Implementation Council:** States must establish a Development and Implementation Council to collaborate on program design and implementation. The Council must have majority membership of the elderly, people with disabilities, or their representatives.
- **Quality Systems and Data:** States must develop quality systems that incorporate consumer feedback and monitor health measures. The state must submit program reports to the Department of Health and Human Services.

Why this is important

States currently have an option to provide personal care services through their Medicaid plans, and 35 states currently do that. This option expands on those programs. It allows states to open eligibility to people at higher incomes and to offer additional services. The increased federal matching payment is a strong incentive for states to take up the option and expand home- and community-based care services in Medicaid. The option could pave the way for even broader expansions of home- and community-based services in Medicaid.

The State Balancing Incentives Payment Program

What it is

A temporary program that provides qualifying states with either a 2 or a 5 percentage point increase in their federal match for Medicaid Home- and Community-Based Services (HCBS) costs. Participating states must make certain program changes designed to increase use of HCBS in Medicaid. This program runs from October 1, 2011 through September 30, 2015. The Department of Health and Human Services (HHS) has a maximum of \$3 billion available for this program.

This applies to a state's existing HCBS Medicaid program and makes no changes in eligibility or benefits provided through Medicaid.

States eligible for added payments

States where less than 50 percent of Medicaid long-term services spending for fiscal year 2009 was on non-institutional care are eligible for Balancing Incentive payments.

Medicaid services that are considered to be non-institutional services for purposes of the program include: home health care; HCBS waivers provided under 1915(c), (d), or (i) or under an 1115 demonstration project; personal care services; certain PACE program services; and 1915(j) self-directed personal assistance services.

State requirements

- **Application and target percentages:** States must submit an application with a budget and plan for increasing Medicaid HCBS spending to a target percentage by September 30, 2015. The target percentages are:
 - 25 percent, if Medicaid HCBS spending was less than 25 percent in 2009, or
 - 50 percent for other balancing incentive states.
- **Administrative changes:** Within six months of applying, the state must institute administrative changes designed to increase HCBS use in Medicaid, including:
 - “No-wrong door single entry point system” that will enable consumers to gain access to all long-term services through a single point where they will receive information on services available and referral services and will receive an assessment to determine financial and functional eligibility for various programs.
 - “Conflict-free” case management to develop individual service plans and to arrange for and conduct ongoing monitoring of services (i.e., no conflict of interest regarding the case managers and the service providers).
 - Core standardized assessment instrument to be used statewide to determine eligibility and appropriate services.
- **Reporting:** States must report services and quality data and report on outcomes measures for non-institutional Medicaid long-term services (i.e., no conflict of interest regarding the case managers and the service providers).
- **Maintenance of Effort:** Maintain 2009 eligibility levels for all non-institutional Medicaid services for which the states will get an added federal payment percentage (see below).

Added Federal Payment (FMAP) Increase

Balancing incentive payments will be based on state expenditures for the non-institutional services (see “States eligible for added payments,” above, for included services). All payments must be used to expand Medicaid non-institutional long-term services.

- States that use less than 25 percent of Medicaid long-term services spending on non-institutional care in 2009 will be eligible for a 5 percentage point FMAP increase, applied to state non-institutional care spending in Medicaid.
- States with spending of at least 25 percent but less than 50 percent are eligible for a 2 percentage point FMAP increase.

Why this is important

The administrative changes required by this program have been used in some states. They are associated with an increase in the use of non-institutional services in Medicaid and, over time, they reduce the growth in Medicaid long-term care spending. However, making those administrative changes can cost money. The added FMAP payment will help states make these changes and strengthen home- and community-based-services in their state.

Changes to Medicaid's 1915(i) Option for Home- and Community-Based Care

What it is

Health reform makes improvements to Medicaid's existing state plan option for providing Home- and Community-Based Services (HCBS), 1915(i). This option became available in 2005. It allows states to offer HCBS under a Medicaid state plan to individuals who are Medicaid-eligible. It limits eligibility to individuals with incomes up to 150 percent of poverty who, but for the program services, would need an institutional level of care. Only four states have taken up the option at this time. The changes to 1915(i) make the program meet more of the standard Medicaid requirements for services offered through a state plan. They expand consumer protections, give states more flexibility in some areas, and require that states do more in other areas. All changes to this program become effective April 1, 2010.

Eligibility

The changes in the law expand eligibility and eligibility protections and give states more flexibility.

- **Protection against eligibility loss with program change.** Currently eligible individuals will be grandfathered into the program as long as they continue to meet the criteria under which they initially received eligibility. Under the original program, a person could lose program services if the state changed income or need-based eligibility criteria.
- **State option to expand program.** Gives states the option to expand the program to include individuals eligible for a HCBS waiver who have incomes up to 300 percent of Supplemental Security Income (SSI). Prior 1915(i) eligibility was limited to 150 percent of poverty.
- **State option to create new Medicaid category.** Allows states to create a new category of Medicaid eligibility for individuals who meet income and functional need eligibility requirements for 1915(i). This change would allow states to offer these services to more individuals. As initially structured, states could only offer 1915(i) programs to people who were Medicaid-eligible. The many states that do not extend Medicaid eligibility up to 150 percent of poverty could not take advantage of the program's upper-end eligibility without expanding the entire Medicaid program. This change allows states to create a new optional Medicaid eligibility category to provide full Medicaid benefits to people who receive services under a 1915(i) program.

Benefits

- **Allows states to offer other services.** Health reform gives states the flexibility to offer services not listed in the statute if approved by the Centers for Medicare and Medicaid Services.
- **Allows states to target services.** States can target services to specific populations and provide different services to the target population for the first five years of program operation, an option that was not available under 1915(i). During that five-year period, states can phase in services, provided that all eligible individuals in the state are enrolled at the end of the five-year period. States can request a five-year renewal for the option to target services. These requests will be considered by the Centers for Medicare and Medicaid Services based on state performance during the first five years.

State Requirements

- **Eliminates the option to limit number of eligibles.** States no longer have the option to limit the program by capping the number who would be granted eligibility, an option that was available under the initial program.
- **Eliminates option to waive statewideness.** States have not been required to offer this program statewide but now will be required to do so.

Why this is important

Few states have taken up the 1915(i) option. One of the issues for states has been the income limitation and lack of an optional Medicaid eligibility category to capture higher income participants. The law addresses that and other program limitations. At the same time, it makes changes that will require programs to be open to more participants (statewide)—also a change that makes this state plan amendment more in line with general Medicaid state plan requirements—and adds consumer protections in the event of program changes.

The Community Living Assistance Services and Supports (CLASS) Program

What it is

A national voluntary program to help people insure against the cost of long-term services. The program is to be established in January 2011, although exact dates for initial enrollment are not specified in the law.

Eligibility

- **To enroll:** The CLASS program will be open to all working adults who have a taxable income. There is no health rating, so individuals can sign up regardless of health; health status will not affect the premium one pays.
- **For benefits:** Individuals must have been enrolled in the program for a minimum of five years before becoming eligible for benefits (vesting period). To receive benefits,

individuals also need to meet the program requirements on functional limitations. The law states that individuals will be eligible for benefits when they need assistance with a minimum of either two or three activities of daily living. Program requirements regarding functional limitations will be developed through the regulatory process.

Premiums

- **Financing of program:** The CLASS program will be financed by enrollee premiums.
- **Premium levels:** The premium levels are not yet established except in the following two categories: people with incomes below 100 percent of poverty and full-time students under the age of 22 who meet the work requirement. The baseline premium for both groups is \$5 a month. That monthly premium will increase annually based on the consumer price index for urban consumers (CPI-U). For others, premiums will vary by age at enrollment. Premiums will not change unless:
 - The individual no longer meets student or low-income status criteria.
 - Enrollment lapses. For a lapse of between three months and five years, at re-enrollment, premiums are recalculated (age-adjusted); also, prior months of enrollment are credited toward meeting the five-year vesting requirement. If enrollment lapses five years or more, premiums are recalculated based on age, there is a re-enrollment penalty, and all prior payment credits for meeting the vesting period are lost.
 - Increases are needed to ensure program solvency. Enrollees over 65 who are no longer working or who have been in the program 20 years are exempt from a solvency-related increase (see below).
- **Annual rate setting:** Annually, the Secretary of the Department of Health and Human Services will set premium levels so that the program will remain solvent for 75 years.

Benefits

- **Amount of benefit:** The program will provide a cash benefit. There will be multiple benefit levels. An individual's benefit will be determined based on a functional needs assessment. Details on program benefit levels are not yet established, but the average benefit must be at least \$50 a day, which is \$18,250 a year. Benefit payments will increase annually, based on the CPI-U.
- **Uses of benefit:** The cash payment can be used to purchase nonmedical services and supports needed to help an individual remain living in the community. This can include, but is not limited to, paying for home modifications, personal assistance, transportation, assistive technology, respite care, and homemaker services.
- **Lifetime benefit.** The CLASS program provides a lifetime benefit; that means that it pays benefits for as long as an individual meets eligibility criteria.

Exercising the benefit option and opting out

- **Employer-based enrollment:** Systems will be established for employers to automatically enroll individuals; premiums will be deducted from paychecks. Employers do not have to participate in this process. Alternate systems will be set up for the self-employed, people with two jobs, and individuals whose employers do not participate in auto-enrollment.
- **Opting out:** Enrollment is voluntary. Individuals do not have to sign up or can notify their employer that they want to opt out at any time. There will be certain times in the year when opt-out elections become effective. Those have not been determined. While individuals can elect to get out at any time, that election will only become effective during an annual disenrollment period.

Program administration

There is a limit on program administrative expenses. Funds will be deposited into a CLASS Independence Fund. An advisory council will be appointed to assist with benefit design.

Program benefits will not affect eligibility for other assistance programs. For individuals also eligible for Medicaid, benefits will help offset Medicaid costs, although enrollees will be able to retain a portion of the program's cash benefit payments.

The program also requires that a Personal Care Workforce Advisory Panel be established to advise Congress and the Secretary of Health and Human Services on workforce issues, to help expand the direct care workforce.

Why this is important

This is a major opportunity to shift the way Americans pay for long-term services. It is the first national long-term care insurance program open to everyone. It could expand individuals' ability to pay for long-term services and increase general awareness of the need for long-term care planning.

Expanded Spousal Impoverishment Protection in Medicaid

What it is

Today, when one member of a couple is receiving long-term care in an institution, states are required to allow the community-dwelling spouse to retain a certain amount in assets and income without affecting the Medicaid eligibility of the spouse living in the institution. This means that both members of a couple do not have to become impoverished for one to receive long-term services in Medicaid. Until health reform, this protection did not apply if the spouse needing care was not institutionalized. With health reform, states will be required to extend the same spousal impoverishment protections that apply to institutional care to home- and community-based care. This provision becomes effective in 2014 and applies for five years.

Why it is important

As long as spousal impoverishment protections only apply to the cost of nursing facility care, couples may have to make the difficult decision to move the spouse needing care to an institution so that the spouse not needing long-term care is not impoverished. That not only means that the person receiving care might be getting that care in the less restrictive setting, but can ultimately cost the state more money, since institutional care is typically more expensive than community-based care. Extending spousal impoverishment protections makes sense and helps put HCBS in Medicaid on an equal footing with institutional care—at least for the five years this provision is in effect.

Extending Money Follows the Person Demonstration Project**What it is**

The Money Follows the Person demonstration project, which helps Medicaid-eligible individuals transition from institutions back to the community, is extended another five years. The institutional residency requirement is changed. A person can be eligible after residing in a nursing facility for three months, a reduction from the prior six-month requirement.

Why it is important

Money Follows the Person has been taken up by many states and has proven to help many move back into a community setting. The reduction in the nursing facility residency requirement will mean more individuals will be eligible for the program sooner, and the transition may be less disruptive.

Additional Funding for Aging and Disability Resource Centers**What it is**

\$10 million annually appropriated each year, 2010 through 2014 to fund aging and disability resource centers. The centers are a collaboration of the Centers for Medicare and Medicaid Services and the Administration on Aging.

Why it is important

The goal of the Aging and Disability Resource Center program is to have, in every community, a visible, trusted place for individuals to get information on long-term care options and to help streamline the process for getting access to this care. Additional funding for these programs will provide support for the other components of health reform that are aimed at expanding access to appropriate, specifically community-based, long-term care.

Part of a series of fact sheets, issue briefs, and special reports designed to help the public understand the new health reform law.



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